HCFA LEGISLATIVE SUMMARY

August 1, 1984

DEFICIT REDUCTION ACT OF 1984 (P.L. 98-369)

On July 18, 1984, the President signed into law H.R. 4170, the Deficit Reduction Act of 1984 (P.L. 98-369). This new law includes many provisions affecting the Medicare and Medicaid programs. Summaries of these changes are attached.

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Attachment

DEFICIT REDUCTION ACT OF 1984

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C. Medicaid Provisions

DEFICIT REDUCTION ACT OF 1984

MEDICARE REIMBURSEMENT AND BENEFIT CHANGES

Modification of Working Aged Provision (Section 2301)

Current Law: Medicare is a secondary payer for workers and their spouses aged 65 to 70, who are covered by an employer's group health insurance. The employer must offer these aged employees the same health benefits as other workers.

Modification: This provision extends the rule of Medicare as secondary payor to the spouses aged 65 to 70 of workers under age 65 whose employer group health insurance covers such spouses.

Effective Date: January 1, 1985.

Part B Premium (Section 2302)

Current Law: The Supplementary Medical Insurance, or part B, program is financed by a combination of premiums from enrollees and general revenue contributions. Through Calendar Year 1985, the monthly premium amount is calculated so as to produce premium income equal to 25 percent of estimated program costs for enrollees aged 65 and over.

Beginning with Calendar Year 1986, the premium calculation will revert to an earlier method under which the premium amount is the lower of: (1) an amount sufficient to cover one half of program costs for the aged; or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the Social Security program.

Modification: The provision extends the requirement that the part B premium produce income equal to 25 percent of program costs through 1987 with the caveat that the increase in the part B premium may not exceed the dollar amount of the Social Security COLA adjustment.

Effective Date: Premiums for months beginning with January 1986.

Payment for Clinical Diagnostic Laboratory Tests (Section 2303)

Current Law: Outpatient diagnostic laboratory services are reimbursed on the basis of reasonable charges, subject to the part B deductible and coinsurance, when furnished by an independent laboratory or a physician. Assignment is permitted on a case-by-case basis. Physicians may bill for laboratory services regardless of whether or not they personally performed or supervised the test. Physicians are permitted to bill a nominal amount to cover specimen collection and handling fees in the case of those tests performed by an independent laboratory. In order to prevent unreasonable mark-ups, certain limits are applied on the amount Medicare and Medicaid will pay a physician for laboratory services furnished by an independent laboratory.

Payment for hospital laboratory services to outpatients is on the basis of the lower of charges or reasonable costs. Hospitals providing these services to their outpatients must accept assignment. No assignment is required in the case of nonhospital patients receiving lab services from a hospital serving as an independent lab.

Medicare is permitted to waive the coinsurance requirements for those tests furnished by a laboratory that has a negotiated rate agreement in effect with the Department.

Modification: The provision establishes fee schedules on a statewide, regional, or carrier-wide basis for the fee screen year beginning July 1, 1984. For independent laboratories, physicians, and hospital laboratories acting as independent laboratories (i.e., furnishing tests to nonhospital patients), the fee schedule is set initially at 60 percent of prevailing charges; for hospital laboratories serving hospital outpatients, the initial level is 62 percent of prevailing charges. After three years, payment for lab services furnished by independent laboratories and physicians is to be made on the basis of a national fee schedule and, for hospital lab services to outpatients, on the basis of cost reimbursement unless Congress includes these labs in a national fee schedule.

The fee schedules will be adjusted annually to reflect increases or decreases in the Consumer Price Index for All Urban Consumers. The Secretary may also make adjustments or exceptions to the fee schedules to assure adequate reimbursement for: emergency lab tests needed for bona fide emergency services; certain low-volume, high-cost tests where highly sophisticated equipment or highly skilled personnel are necessary to assure quality; technological changes; and the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based. Federal matching funds will not be available to the extent that a State paid more for a lab test than would be paid for such a test under the Medicare fee schedules.

The provision modifies the current assignment and billing options. Independent and hospital laboratories are required to accept assignment. Physicians may continue to accept assignment on a claim-by-claim basis. All assigned laboratory tests will be paid at 100 percent of the fee schedule amount (or, if lower, the actual charge). Coinsurance and deductible will not be applied to assigned laboratory charges. Unassigned laboratory bills will be paid at 80 percent of the fee schedule amount, subject to deductible and coinsurance.

Direct billing is required for all part B laboratory services. That is, physicians may bill for laboratory services only when they personally perform or supervise the test. However, the Secretary may permit an independent laboratory to bill for all tests performed for a patient even if some (but not all) of the tests were referred to another laboratory.

Anyone who furnishes lab services may bill a nominal amount for the collection of a patient specimen, however, only one collection fee per patient encounter will be permitted.

The Secretary is required to simplify current billing requirements for laboratory services and to assure that the information collected is sufficient to prevent fraud and abuse.

The Secretary is required to report on the advisability and feasibility of providing for direct payment to physicians for all clinical diagnostic tests ordered by them. The General Accounting Office (GAO) is to report on the impact of the fee schedule on services, the potential impact of the move to national rates, and the impact of such a fee schedule on hospital outpatient services. Both reports are due January 1, 1987.

Effective Dates: Medicare diagnostic tests provided on or after July 1, 1984; Medicaid payments for calendar quarters on or after October 1, 1984.

Pacemaker Reimbursement Review and Reform (Section 2304)

Current Law: Reimbursement for inpatient hospital services for implantation of cardiac pacemakers is included in the Medicare prospective payment. Reimbursement for physicians' services, and postimplantation monitoring of pacemakers, continues to be reimbursed under part B. Coverage guidelines published in 1980 establish a frequency of postimplant monitoring to be used in screening whether claims are "reasonable and necessary".

Modification: The Secretary is required to revise current guidelines on the frequency of transtelephonic monitoring. If she fails to revise the guidelines by October 1, 1984, a frequency schedule for monitoring single-chamber cardiac pacemakers powered by lithium batteries specified in the law will be put into effect. The statutory guidelines would expire on publication of the revised guidelines.

The Secretary is required to review the appropriateness of current reimbursement for physicians' services associated with the implantation or replacement of pacemakers and report to Congress. A review of inpatient hospital services is to be conducted by the Prospective Payment Assessment Commission. Both studies are due to Congress by March 1, 1985.

The Food and Drug Administration is to establish a registry for all pacemaker devices and leads for which Medicare payment is made. The registry would include, among other things, information on the device, the implantation procedure, and any applicable warranties. Compliance with information requirements may be a condition for Medicare payments for providers and physicians.

Effective Date: Revised monitoring guidelines for services furnished on or after October 1, 1984 or, if earlier, when issued by the Secretary; pacemaker registry for services furnished on or after January 1, 1985.

Elimination of Special Payment Provisions for Preadmission Diagnostic Testing (Section 2305)

Current Law: The Omnibus Reconciliation Act of 1980 (P.L. 96-499) authorized 100 percent reimbursement (on a reasonable cost or charge basis) for preadmission diagnostic testing, either in a hospital's outpatient department or in a physician's office, within seven days prior to a hospital admission.

Modification: The special payment provisions are repealed with an explanation that the repeal shall not be construed as prohibiting payment (subject to cost-sharing) for preadmission diagnostic testing performed in a physician's office to the extent such testing is otherwise reimbursable.

Effective Date: Services provided after the date of enactment.

Limitation on Physician Fee Prevailing and Customary Charge Levels; Participating Physician Incentives (Section 2306)

Current Law:

- Physician Fees -- Medicare pays for physicians' services on the basis of Medicare-determined "reasonable charges". Reasonable charges are the lesser of: (1) a physician's billed charge; (2) the customary charge made by an individual physician for a specific service; or (3) the prevailing level of charges made by all physicians for services in a geographic area. The customary and prevailing charges are updated annually (on July 1) to reflect changes in physician charging practices. Increases in the prevailing charge levels are limited by an economic index, which reflects changes in the physicians' practice costs and changes in general earnings levels.

- Participating Physician Arrangements -- Physicians may decide, on a claim-by-claim basis, to accept assignment. That is, for each claim a physician may decide either (1) to accept the amount paid by Medicare (the reasonable charge) as payment in full (except for cost-sharing amounts) or, (2) to bill the patient for the entire bill, including any amount in excess of the Medicare reasonable charge. The patient is then responsible for paying the physician for the full amount of the bill and for submitting the claim to Medicare for payment of 80 percent of the Medicare reasonable charge.

Modification: For fifteen months beginning July 1, 1984, Medicare customary and prevailing charges for physician services are frozen at the levels that were in effect for the twelve-month period ending June 30, 1984. In addition, during the period of the freeze, nonparticipating physicians are not permitted to increase their actual billed charges to Medicare patients. Participating physicians are allowed normal increases in their actual charges to Medicare patients during the freeze period. These normal increases will be recognized in future calculations of customary charges of participating physicians.

A participating physician is one who voluntarily signs an agreement before October 1st of a year to accept assignment for all services provided to Medicare patients during the following twelve-month period. Nonparticipating physicians are allowed to accept assignment on a claim-by-claim basis.

Incentives for physician participation include directories of participating physicians, dissemination of names of participating physicians via toll-free telephone lines, and provision for electronic receipt of claims by carriers. Increases in actual charges of nonparticipating physicians during the freeze period will not be recognized in future customary charge screen calculations. Nonparticipating physicians who increase their actual charges could be subject to civil money penalties and/or exclusion from the Medicare program for up to five years.

Effective Date: July 1, 1984.

Payment for Services of Teaching Physicians (Section 2307)

Current Law: Medicare may reimburse physicians in teaching hospitals on a reasonable charge basis if certain conditions are met: the physician must exercise full personal control over the management of the patient's care; services are of the same nature as those furnished by the physician to nonbeneficiaries; and at least 25 percent of the hospital's non-Medicare patients must pay all or a substantial part of the charges (including the Medicaid payments) for similar services rendered to them. The law allows use of an optional mean or mode test to establish customary charges for physicians who do not have an outside practice. Cost reimbursement to hospitals is allowed where all physicians elect to be so reimbursed.

Modification: The new provision expands the mean or mode test by placing a floor on customary charges of teaching physicians at 85 percent of the prevailing charge. In addition, if all the teaching physicians at a particular teaching hospital agree to take assignment for all Medicare patients they serve in that hospital, their customary charges are set at 90 percent of the prevailing charges in that locality. The new provision also gives the Secretary discretion in defining teaching physicians.

The Secretary, when calculating a hospital's indirect teaching costs, must take into account not only the residents and interns employed by the hospital but also any other house staff members who participate in the hospital's teaching program but who are employed by another organization.

The GAO will study the amounts billed for the services of teaching physicians and paid by carriers to determine whether such payments are only made when all of the conditions for payment under present law are met. The study is due not later than 18 months after enactment.

Effective Date: Services provided on or after July 1, 1984; for the indirect teaching cost provision, cost reporting periods beginning on or after October 1, 1984.

Lesser of Cost or Charges (Section 2308)

Current Law: Medicare pays providers the lesser of costs or charges (LCC). HCFA requires hospitals to aggregate both inpatient and outpatient services to determine costs and charges. However, public providers whose charges are nominal -- that is, less than 50 percent of costs -- are exempt from LCC and reimbursed on the basis of costs.

Modification:

- Separate Calculations -- For the purposes of determining both the lesser of costs or charges and nominal charges, the Secretary is required to segregate inpatient and outpatient services (optional for home health services). Clinical laboratory services performed by hospitals for outpatients will be excluded from this calculation.

- Nominal Charge Rule -- Charges will be considered nominal if they are less than or equal to 60 percent of costs. The nominal charge exemptions may also apply to non-public providers who serve a significant proportion of low income individuals.

Effective Date: Cost reporting periods beginning on or after October 1, 1984.

Study of Medicare Part B Payments (Section 2309)

Current Law: Payments are made to physicians on the basis of reasonable charges for specific services.

Modification: The provision requires that the Office of Technology Assessment (OTA) conduct a study of Medicare part B payments. The report will include findings and recommendations for modification of payment methods and policies to:

- Eliminate inequities in physician reimbursement by service, specialty, cognitive vs. medical procedures, and locality, including information on the development of fee schedules; and

- Increase incentives for physicians and suppliers to accept assignments, including the influence of payment methodology on utilization of services.

The Secretary is required to compile for OTA a centralized Medicare part B charge data base using 1983 charge data. In addition, the Secretary is required to review the OTA report and make comments with legislative recommendations to the Congress.

Effective Date: Due to Congress by December 31, 1985.

Limitation on Increase in Hospital Costs per Case (Section 2310)

Current Law: Effective October 1, 1982, the Tax Equity and Fiscal Responsibility Act, TEFRA (P.L. 97-248), expanded limits on Medicare routine costs per day to total costs per case. It also established a target rate reimbursement system which limited allowable rates of increase in Medicare payments per case over the Fiscal Year 1983-Fiscal Year 1985 period. The target rate is equal to the previous year's allowable operating costs per case (or after the first year, the previous year's target amount) increased by the percentage increase in the cost of the mix of goods and services used to provide inpatient hospital services (market basket) plus one percentage point.

The Social Security Amendments of 1983 (P.L. 98-21) provided for the establishment of a prospective payment system for certain hospitals. For Fiscal Year 1984 and Fiscal Year 1985, payment amounts for hospitals operating under the prospective payment system and for hospitals and hospital units exempt from the system would be increased by the market basket plus one percentage point. For fiscal years beginning on or after October 1, 1985, the rate of increase is left to the discretion of the Secretary.

Modification: The rate of increase for hospitals operating under the prospective payment system and for exempt hospitals and hospital units will be equal to market basket plus one quarter of one percentage point in Fiscal Year 1985, subject to budget neutrality. In Fiscal Year 1986, the rate of increase shall not exceed market basket plus one quarter of one percentage point.

Effective Date: Cost reporting periods beginning and discharges occurring on or after October 1, 1984.

Classification of Certain Rural Hospitals (Section 2311)

Current Law:

- Redesignation of Urban Facilities -- The prospective payment system provides for payment per case to hospitals based on diagnosis related groups (DRGs). The system is to be phased in over a three-year transition period during which a declining portion of the total of the prospective payment will be based on a hospital-specific rate and an increasing portion on a Federal rate. Different Federal rates are calculated for hospitals located in rural and urban areas.

  Urban areas are metropolitan statistical areas (currently MSAs, previously SMSAs) or New England county metropolitan areas (NECMAs) as well as five specified counties in New England. All other areas are rural areas. The determination of whether or not an area is urban or rural is made by the Office of Management and Budget and is periodically changed. In June 1983, 49 counties were redesignated from an urban to a rural area. Thus, hospitals which had expected to receive the higher urban Federal payment suddenly received a lower rural payment.

- MSAs Crossing Census Lines -- Separate Federal rates are calculated for the nine census division regions. In some cases, MSAs cross census division boundaries resulting in some hospitals in the MSA receiving different Federal payments from other hospitals in the MSA who are in a different census region.

- Regional and National Referral Centers -- Under the prospective payment system, the Secretary may provide exceptions and adjustments appropriate to regional and national referral centers, including those hospitals of 500 or more beds located in rural areas.

Modifications:

- Redesignation of Urban Facilities -- Hospitals located in counties redesignated as rural since enactment of the prospective payment system are allowed a two-year transition to the rural rates. In the first year, the hospital's Federal payment will be the rural rate plus two thirds of the difference between its rural and urban rate. In the second year, it will be paid the rural rate plus one third the difference between the rural and urban rates.

- MSAs Crossing Census Lines -- A hospital located in an MSA shall be deemed to be in the region in which the greatest number of hospitals are located or, at the option of the Secretary, the region which accounts for the greatest number of Medicare discharges.

- Regional and National Referral Centers -- A hospital classified as a rural hospital may appeal to be classified as a rural referral center, based on criteria established by the Secretary within 30 days following enactment. The criteria will allow a hospital to demonstrate that it should be reclassified by reason of certain operating characteristics being similar (including wages, scope of services, service area, and medical specialties) to those of a typical urban hospital in the same region. The appeal must be submitted during the quarter prior to the beginning of the hospital's cost reporting period (or by December 31, 1984 for hospitals with cost reporting periods beginning October 1, 1984). The final determination on an appeal will be made within 60 days and will be effective with the beginning of the cost reporting period.

- Studies -- The Secretary will review the effect on rural hospitals of payments for DRGs which have high fixed nonlabor components that do not vary significantly between urban and rural areas (such as DRGs involving expensive medical devices). The Secretary will also study the advisability and feasibility of varying by DRG the proportion of labor and nonlabor components of the Federal payment amount, instead of applying an average proportion to all DRGs A report will be sent to the Senate Committee on Finance and the House Committee on Ways and Means within six months following enactment.

The Secretary will also study further refinements to prospective payments, including the degree of variation in inpatient hospital costs per discharge within each DRG and the merits of determining a percentage of the payment amount on a regional basis. The results of this study, including any recommendations, must be forwarded to Congress prior to September 1, 1984.

Effective Dates:

Redesignation of Urban Facilities	Cost reporting periods beginning on or after October 1, 1983.
MSAs Crossing Census Lines	Cost reporting periods beginning on or after October 1, 1983, except that no payments will be lowered before October 1, 1984.
Regional and National Referral Centers	Cost reporting periods beginning on or after October 1, 1984.
Studies	Six months following enactment and September 1, 1984.

Payment for Services of a Nurse Anesthetist (Section 2312)

Current Law: Under the prospective payment system, all inpatient nonphysician services must be paid under part A. However, the prospective payment regulations established a transition period for payment for the services of certified registered nurse anesthetists (CRNAs) billed under part B. The regulations provide that if a physician employed nurse anesthetists for a designated period prior to the implementation of the prospective payment system, the physician may continue to receive payment from part B for CRNA services through hospital cost reporting periods beginning before October 1, 1986.

Modification: The cost of anesthesia services furnished by CRNAs (including the preparation of, administration of, and recovery from anesthesia) are excluded temporarily from the "operating costs of inpatient hospital services" and will be reimbursed on a "pass through" basis.

The Secretary will pay a hospital operating under the prospective payment system an additional amount for the hospital's reasonable costs incurred for services provided by CRNAs.

The Secretary will also study reimbursement methods that will not discourage the use of CRNAs by hospitals and report the results to Congress as soon as practicable.

Effective Date: Cost reporting periods beginning on or after October 1, 1984 and before October 1, 1987.

Prospective Payment Assessment Commission (Section 2313)

Current Law: The Prospective Payment Assessment Commission assists the Department and Congress with issues concerning the prospective payment system. The Commission must make recommendations concerning the annual percentage increase factor for prospective payment rates and changes in the DRGs based on its evaluation of scientific evidence concerning new practices, technologies, and treatment modalities.

Modifications: The status of the Commission as an independent body responsible for requesting appropriations is clarified. The Commission is authorized to employ an Executive Director and other personnel without regard to provisions governing appointments in the competitive service. Commission meetings may be closed to the public by a majority vote of the members. The Secretary may supplement Commission activities by carrying out or awarding grants or contracts for original research and experimentation, including clinical research in certain instances. Physicians serving as Commission personnel may be provided a physician comparability allowance.

Effective Date: Upon enactment.

Revaluation of Assets (Section 2314)

Current Law: Medicare reimburses hospitals and other providers for their capital-related costs, including depreciation costs, interest, and, for proprietary facilities, return on equity capital. Regulations allow revaluation upwards to the lower of the selling price, fair market value, or current reproduction cost. The costs of the transaction, such as legal fees, negotiations, and settlements are allowed. Rental charges are limited by regulation to the amount which would be allowable if the provider had title on sale and leaseback arrangements. When an asset is sold above its depreciated value, Medicare shares in the gain, up to the amount of depreciation paid on the asset.

Modification:

- Revaluation under Medicare -- The provision restricts reimbursement for capital upon the change of ownership of a hospital or skilled nursing facility (SNF) to the lesser of the cost under Medicare to the owner of record on enactment (or, if later, the first owner of record) or the purchase price, thereby eliminating upward revaluation. Costs of legal fees, negotiation, or settlement of the sale are not reimbursable. The Secretary is required to take into account the limit on revaluation when establishing reimbursable rental charges in sale and leaseback agreements. The recapture of depreciation up to the full value of the initial asset under Medicare is required.

Effective Date: Contracts obligated on or after the date of enactment.

- Revaluation under Medicaid -- States are required to provide assurances satisfactory to the Secretary that the methodologies used to establish capital

reimbursement of hospitals, skilled nursing facilities, and intermediate care facilities can reasonably be expected not to increase those rates more than they would increase under Medicare policy as the result of a change in ownership.

Effective Date: Medical assistance provided on or after October 1, 1984 except that, in those cases where State legislation is required, the State will not be deemed out of compliance until the first calendar quarter after the close of the first regular session of the State legislature that starts after the date of enactment.

Technical Amendments Relating to the DRG Payment System (Section 2315)

Current Law:

- State Systems -- The prospective payment legislation permitted hospitals to be paid under a State reimbursement control system rather than the prospective payment system, provided that certain conditions are met.
- Public Comment -- The Secretary is required to publish in the Federal Register for public comment the proposed and final annual index of DRGs.
- Peer Review Organization (PRO) Agreements -- A requirement that hospitals enter into agreements with PROs applies only to those hospitals subject to the prospective payment system.

Modification:

- State Systems -- Approved State systems will be required to include all non-physician services to hospital inpatients in the hospital payment and prevent inappropriate admissions practices.
- Public Comment -- Public comment is required only on the proposed annual index.
- PRO Agreements -- Hospitals exempt from the prospective payment system must also have agreements with PROs.
- Effective Dates -- Provisions in the prospective payment legislation related to State programs and exempt hospitals are also effective October 1, 1983. Proposed regulations concerning State system requirements must be published by July 1, 1984 and (after a 45-day comment period) final regulations must be published by October 1, 1984.
- Hospitals Serving Low-Income Persons -- The Secretary is directed to develop and publish a definition of a hospital that serves a disproportionate number of low-income individuals or individuals who are entitled to benefits under part A. The Secretary will identify such hospitals by December 31, 1984 and report their identity to the Senate Committee on Finance and the House Commitee on Ways and Means.

Effective Date: October 1, 1983 for all provisions except the definition and report on hospitals serving low-income persons.

Prospective Payment Wage Index (Section 2316)

Current Law: Medicare payments to hospitals under the prospective payment system must be adjusted to reflect the hospital wage level in a hospital's geographic area relative to the national average hospital wage level.

Modification: The Secretary, in consultation with the Secretary of Labor, is required to conduct a study and develop an appropriate hospital area wage index which accounts for the wage differences of full-time and part-time workers. Adjustments will be made to hospital payment amounts to reflect any changes in the wage index by increasing or decreasing payments in succeeding cost reporting periods.

The Secretary will conduct a study and report to Congress on proposed criteria by which a hospital may seek an adjustment if it can demonstrate that the wage adjustment in its area did not accurately reflect the wage levels in the hospital's labor market.

Effective Date: For payment adjustment, cost reporting periods beginning on or after October 1, 1983; for the first study, including any changes to provide an appropriate index, 30 days following enactment.

Deadline for Report on Including Payment for Physicians' Services to Hospital Inpatients in DRG Payment Amounts (Section 2317)

Current Law: The Secretary is required to report to Congress in 1985 on the advisability and feasibility, including legislative recommendations, of including payment for physicians' services provided to inpatients in the hospital DRG payment.

Modification: The Secretary is required to report to Congress no later than July 1, 1985.

Effective Date: Due to Congress no later than July 1, 1985.

Emergency Room Services (Section 2318)

Current Law: The Secretary is required to place reasonable limits on hospital costs and physician charges for outpatient services; bona fide emergency services provided in an emergency room are specifically exempted from the limits.

Modification: The term "emergency services" is defined to specify the general medical conditions under which such a service can be considered a bona fide emergency room service. Such services provided in hospital emergency rooms are exempted from limits that apply to other outpatient services.

Effective Date: Services provided on or after the date of enactment.

Skilled Nursing Facility Reimbursement (Section 2319)

Current Law: TEFRA required the Secretary to establish a single payment limit for both freestanding and hospital-based SNFs effective October 1, 1982. Prior to that time, separate limits were established for these two types of facilities in recognition of the fact that the operating costs of hospital-based facilities were typically much higher than those of the freestanding facilities. Further, the Secretary was required to submit to Congress by December 31, 1982 a report on legislative proposals to implement prospective reimbursement for SNFs.

In the Social Security Amendments of 1983, the effective date of the single limit requirement was postponed for one year until October 1, 1983. In addition, the Congress required the Secretary to report by December 31, 1983 on the effect of the implementation of the single-rate provision on hospital-based SNFs, given the difference (if any) in the patient population served by such facilities and by freestanding SNFs. Further, the Secretary was required to report by the end of 1983 on the impact of hospital prospective payment on SNFs.

Modification: For cost reporting periods beginning October 1, 1982 and prior to July 1, 1984, hospital-based facilities and freestanding facilities will be paid on the basis of the policy for calculating reimbursement limits that had been in effect prior to the passage of TEFRA. Under this system, the limits for freestanding facilities will be set at 112 percent of the average per diem operating costs for urban and rural facilities, respectively. The limits for hospital-based facilities will similarly be set at 112 percent of the average per diem operating costs for urban and rural hospital-based facilities, respectively.

For cost reporting periods beginning on or after July 1, 1984, separate limits will continue to be established for freestanding facilities in urban and rural areas at 112 percent of the mean operating costs of urban and rural freestanding facilities, respectively. Limits for urban or rural hospital-based facilities will be set at the appropriate freestanding facility limit plus 50 percent of the difference between the freestanding facility limit and 112 percent of mean operating costs for hospital-based facilities. In addition, cost differences between hospital-based and freestanding facilities attributable to excess overhead allocations resulting from Medicare reimbursement principles will be recognized as an add-on to the limit for hospital-based SNFs. Adjustments will be made to take account of differences in wage levels prevailing in a facility's area. Exceptions may be granted based upon case mix or circumstances beyond the control of either a freestanding or hospital-based facility.

The Secretary shall submit to Congress prior to December 1, 1984 the report required by the Social Security Amendments of 1983 on the impact of hospital prospective payment on SNFs.

The Secretary is required to submit to the Congress by August 1, 1984 the results of the study required by TEFRA relating to the development of legislative proposals for prospective reimbursement of SNFs. In addition, the Secretary is required to report to the Congress by December 1, 1984 on the range of options available for prospective

payment of SNFs. Included in the study should be an examination of the feasibility, advisability, and methodology of incorporating payments for SNF services into the hospital DRG system. This examination should take into account case mix differences between providers.

Effective Date: Except for required reports, cost reporting periods beginning on or after October 1, 1982.

Payment for Costs of Hospital-Based Mobile Intensive Care Units (Section 2320)

Current Law: Ambulance services are reimbursable under the Medicare part B program when provided by an approved ambulance service to a local hospital or skilled nursing facility only when (1) the ambulance, its equipment, and personnel meet Medicare requirements, and (2) transportation by other means could endanger the patient's health. The patient may also be transported from one of these institutions to his or her home (or place of residence) if it is within the locality of the institution. The patient is responsible for a coinsurance payment of 20 percent.

Modification: The provision provides for Medicare payment to hospitals under part A for the operation of mobile intensive care units if certain conditions are met unless a State requests otherwise. The hospital must be located in the State of New Jersey and operating under a Medicare demonstration project waiver. The State is required to provide satisfactory assurances that total Medicare and Medicaid payments for ambulance services to the hospitals covered under the State system will not exceed the total payments which would have been made if the State were not under the waiver.

Effective Date: Upon enactment and until the waiver is terminated. However, the provision may not be terminated prior to 90 days after the publication of the final regulations implementing section 1886(c) waiver authority.

Cost Sharing for Durable Medical Equipment Furnished as a Home Health Benefit (Section 2321)

Current Law: Medicare payment for durable medical equipment not provided as a covered inpatient service is based on 80 percent of reasonable charges (or 80 percent of reasonable costs in the case of a provider), with one exception: payment is based on 100 percent of costs when furnished as part of a covered home health service provided by home health agencies.

Modification: Durable medical equipment provided by home health agencies will be reimbursed at no more than 80 percent of reasonable cost and the beneficiary will be responsible for a 20 percent coinsurance payment.

Durable medical equipment provided free or at a nominal charge by a public home health agency will be reimbursed at an amount the Secretary finds will provide "fair compensation" to the home health agency.

Effective Date: Items and services provided on or after the date of enactment.

Services of a Clinical Psychologist Provided to Members of an HMO (Section 2322)

Current Law: Services of physician assistants and nurse practitioners are recognized as "medical and other health services" if they are furnished pursuant to a risk-sharing arrangement with a health maintenance organization (HMO).

Modification: "Medical and other health services" is expanded to include the services of clinical psychologists when furnished pursuant to a risk-sharing arrangement with an HMO. The Secretary will determine the qualifications necessary to be identified as a clinical psychologist.

Effective Date: Services provided on or after date of enactment.

Coverage of Administration of Hepatitis B Vaccine (Section 2323)

Current Law: Medicare coverage of immunizations and vaccines is prohibited except in the case of pneumococcal vaccine which Congress specifically covered in 1980 (P.L. 96-611).

Modification: The provision covers hepatitis B vaccine for high and intermediate risk individuals. The Secretary is expected to develop coverage guidelines using available information to define those groups at high and intermediate risk of contracting the disease using specifically, but not necessarily exclusively, the information developed by the Centers for Disease Control. The provision permits separate payment for vaccines for patients receiving dialysis at or through a facility. For non-End-Stage Renal Disease (ESRD) patients, payments may be made to ESRD facilities, hospital outpatient departments, or physicians for the vaccine and its administration. Similar payment arrangements are applicable for vaccines provided to ESRD patients not cared for by an ESRD facility.

The provision gives the Secretary discretion in developing payment amounts that reflect the general cost of efficiently providing such services. The Secretary is directed to monitor the provision of the vaccine and its administration. The Secretary is also required to review any changes in technology which would potentially affect the amounts paid for services.

Effective Date: Vaccines administered on and after September 1, 1984.

Coverage of Hemophilia Clotting Factor (Section 2324)

Current Law: Coverage of drugs and biologicals under the Medicare part B program is limited to the type that cannot be self-administered and are commonly furnished as incident to a physician's services. Prescription and nonprescription drugs and biologicals purchased by or dispensed to a patient are not covered.

Modification: The provision provides Medicare part B coverage, subject to utilization controls deemed necessary by the Secretary, for blood clotting factors and the supplies necessary for the self-administration of the clotting factor.

Effective Date: Items and services purchased on or after date of enactment.

Payment for Debridement of Mycotic Toenails (Section 2325)

Current Law: Routine foot care is not covered by the Medicare program. However, Medicare does allow reimbursment to physicians for debridement of mycotic toenails (i.e., the care of toenails with a fungal infection).

Modification: The provision requires the Secretary to deny coverage under the Medicare program for debridement of mycotic toenails if performed more frequently than once every 60 days. Exceptions will be authorized if medical necessity is documented by the billing physician.

Effective Date: Services provided on or after the date of enactment.

Contracts for Medicare Claims Processing (Section 2326)

Current Law: Medicare contracts with intermediaries and carriers to perform the day-to-day operational work for part A and part B of the program, respectively. Providers are permitted to nominate an intermediary, but they may be reassigned by the Secretary if such reassignment results in more effective administration of the program. Intermediaries and carriers are reimbursed for these activities on a reasonable cost basis, subject to the budgetary limitations imposed by the Health Care Financing Administration (HCFA). Selection of carriers and intermediaries on the basis of competitive bidding is allowed only on an experimental basis.

The Secretary is required to establish by regulation the standards and criteria with regard to effective administration of the part A program by intermediaries.

Modification:

- Competitive Bidding -- The provision allows a waiver of the provider's right to nominate the intermediary when a contract is competitively bid for the duration of that contract. Competitive bids may be made to replace contractors whose performances have repeatedly ranked in the lowest 20th percentile. Such competitions must be among health insuring organizations and are limited to two part A and two part B contracts in Fiscal Year 1985 and Fiscal Year 1986. These contractors must meet all regular contract standards and perform the full range of contractor functions.

- Cost Reimbursement Limits -- The provision requires that, in determining a contractor's necessary and proper costs, the Secretary shall take into account the amount that is reasonable and adequate to meet costs incurred in an efficient and economically run organization.

- Standards and Criteria -- The provision requires that the standards and criteria for part A and part B contracts be published in the Federal Register and that an opportunity be provided for public comment before implementation.

- Home Health Agency (HHA) Regional Intermediaries -- The provision reduces the number of HHA regional intermediaries to not more than 10 by July 1, 1987.

- Study -- GAO is to study the Medicare contracting process and report to the Congress on: whether contractor costs are excessive; whether standards for evaluating costs and performance are adequate and properly applied; and whether the Secretary's authority is sufficient to deal with inefficient contractors either through negotiation and budget review or replacement.

Effective Date: Agreements and contracts entered into or renewed on or after October 1, 1984; study due one year after enactment.

ADMINISTRATIVE AND MISCELLANEOUS CHANGES

Repeal of Exclusion of For-Profit Organizations from Research and Demonstration Grants (Section 2331). The provision extends the research and demonstration grant authority to allow participation by for-profit organizations, which were previously excluded.

Presidential Appointment of and Pay Level for the Administrator of the Health Care Financing Administration (Section 2332). The provision provides that the Administrator of HCFA be appointed by the President with the advice and consent of the Senate, upgrading the position and pay level to level IV of the Executive Schedule. In the past the Administrator was appointed by the Secretary of Health and Human Services.

Exclusion of Certain Entities Owned or Controlled by Individuals Convicted of Medicare- or Medicaid-Related Crimes (Section 2333). The provision extends the Secretary's authority to terminate agreements under Medicare with any entity in which ownership or controlling interest is held by a person or a chief officer convicted of a program-related criminal offense. The Secretary may also require States to make similar exclusions under Medicaid.

Provider Representation in Peer Review Organizations (Section 2334). The provision allows up to 20 percent of a PRO governing board to be affiliated with a provider and allows the board to have no more than one individual affiliated with an HMO or eligible competitive medical plan (CMP).

Repeal of Special Tuberculosis Treatment Requirements under Medicare and Medicaid (Section 2335). The provision repeals the special conditions and requirements associated with coverage of treatment of tuberculosis patients and eliminates the special provider category of tuberculosis hospitals.

Access to Home Health Services (Section 2336). The provision permits physicians who have a financial interest in a sole community HHA to carry out certifications and plan-of-care functions for patients served by the agency. Furthermore, it deletes uncompensated officers or directors from the list of disqualified physicians. Regulations defining sole community HHA must be issued within 90 days after enactment.

Normalization of Trust Fund Transfers (Section 2337). The provision reestablishes the former practice (prior to the Social Security Amendments of 1983) of transferring funds as needed during the month into the Hospital Insurance (HI) Trust Fund from the Treasury, rather than making all transfers for anticipated needs on the first of the month.

Enrollment and Premium Penalty with Respect to Working Aged Provision (Section 2338). A 10 percent part B premium surcharge is normally imposed for each 12-month period after age 65 for which a Medicare beneficiary fails to enroll. This provision provides that any month in which a beneficiary age 65 up to age 70 does not enroll because that individual is covered by an employer group health insurance will not be taken into account in calculating the amount of the premium surcharge. In addition,

special enrollment periods are established upon the termination of coverage by employer group insurance and at age 70 when the working aged provision no longer applies. The penalty relief provision is effective with respect to months beginning with January 1983 for premiums for months beginning at least 30 days after enactment.

Indirect Payment of Supplementary Medical Insurance Benefits (Section 2339). Part B payments generally may not be made to anyone other than a beneficiary or an entity providing services. This provision permits part B payments to be made to an entity providing coverage of the services under a health benefits plan, if the beneficiary agrees and if the physician or other supplier accepts the plan's payment as payment in full.

Certification of Psychiatric Hospitals (Section 2340). This provision eliminates the requirement that psychiatric hospitals participating in Medicare and Medicaid be accredited by the Joint Commission on the Accreditation of Hospitals (JCAH) and that psychiatric units of hospitals be so accredited or meet equivalent requirements.

Including Podiatrists in Definition of "Physician" for Outpatient Physical Therapy Services and Including Podiatrists and Dentists in Definition of "Physician" for Outpatient Ambulatory Surgery (Section 2341). For outpatient physical therapy services, this provision expands the definition of a physician to include podiatrists. For outpatient ambulatory surgery in a physician's office, dentists and podiatrists are now to be included within the definition of physician.

Establishment by Physical Therapists of Plans for Physical Therapy (Section 2342). Under prior law, Medicare payment for outpatient physical therapy services to a beneficiary could be made only if the plan of treatment was established and reviewed by a physician. This provision allows a physical therapist also to establish a plan, although such a plan must still be periodically reviewed by a physician.

Hospice Contracting for Core Services (Section 2343). Coverage of hospice services for the terminally ill with a life expectancy of six months or less is authorized until October 1, 1986. Hospices are required to routinely provide all "core services" (nursing care, medical social services, physician's services, and counseling services) and may only contract these services to supplement employees under extraordinary circumstances.

This provision allows the Secretary, for hospices located in rural areas that were in operation on or before January 1, 1983, to waive the nursing care "core services" requirement, if the hospice has shown good faith in trying to hire its own nurses. In addition, the Secretary is required to submit a report on the core services requirement to the Congress by January 1, 1986. Analysis of Medicare hospices and a review of non-Medicare hospices are to be included in the study.

Medicare Recovery Against Certain Third Parties (Section 2344). In cases where Medicare is a secondary payer, this provision establishes the right of Medicare to recover directly from third parties even if the beneficiary does not bring action. It also permits Medicare to intervene in any action to obtain payment from a third party payer, and subrogates Medicare to any right of the beneficiary or anyone else to payment from the third party payer.

Confidentiality of Accreditation Surveys (Section 2345). The provision extends protection against disclosure of JCAH survey information provided to the Secretary to similar surveys performed by the American Osteopathic Association or other national accreditation organizations.

Use of Additional Accrediting Organizations under Medicare (Section 2346). This provision extends the Secretary's authority to rely on accrediting organizations in determining whether rural health clinics; laboratories; clinics; rehabilitation agencies, including outpatient rehabilitation facilities; psychiatric hospitals; hospices; and public health agencies meet Medicare requirements or meet equivalent health and safety requirements for participation under Medicare (and clarifies the Secretary's authority with respect to ambulatory surgical centers).

Funding for PSRO Review (Section 2347).

- Payments - This provision requires a hospital to enter into an agreement with a PSRO if one is in existence in its area as a condition for Medicare payment. PSROs are to be funded out of the Medicare HI Trust Fund as a benefit cost and are not subject to appropriations.

- PRO Agreements - This provision changes from October 1, 1984 to November 15, 1984 the date by which hospitals must have an agreement with a PRO. Similarly, November 15, 1984 becomes the first date on which payer organizations could qualify as PROs.

Payment for Services Following Termination of Participation Agreements with Home Health Agencies or Hospice Programs (Section 2348). Formerly, when the Medicare participation agreement of an HHA or a hospice was terminated, payment for services to a beneficiary continued until the end of that calendar year. Effective for all terminations issued on or after the date of enactment, this provision reduces the period during which payments for services provided to beneficiaries are continued to 30 days.

Elimination of Health Insurance Benefits Advisory Council (Section 2349). This provision repeals the requirement that the Secretary appoint a 19-member panel of health experts to advise on general policy affecting the Medicare and Medicaid programs.

Health Maintenance Organizations and Competitive Medical Plans (Section 2350).

- Enrollment -- The provision requires the Secretary (in consultation with HMOs and CMPs in an area) to designate a single 30-day period each year during which they would hold open enrollment for Medicare beneficiaries. The Secretary is expected to take steps to assure that an appropriate portion of capacity is retained to enroll Medicare beneficiaries in the HMO or CMP.

- Benefits Stabilization Fund -- This provision allows an HMO or CMP to request that the Secretary withhold part of the expected Medicare payments (when the adjusted community rate of Medicare enrollees is less than Medicare payments) for use in subsequent contract periods. These funds would be used to avoid significant premium changes or fluctuations in benefits to beneficiaries from year to year. The use of such funds is limited to a four-year period and such agreements cannot be entered into more than four years after enactment.

- Direct Reimbursement -- This provision permits a risk-based HMO or CMP to request that Medicare make payment directly to a SNF for services provided to its beneficiary enrollees. Now reimbursement for both risk-sharing and cost-based HMO or CMP services to beneficiaries can be made directly to hospitals and nursing homes.

Judicial Review of Provider Reimbursement Review Board Decisions (Section 2351).

- Appeals -- Under the Social Security Amendments of 1983, providers became entitled to bring a group action in the judicial area where the largest number of providers is located and appeal before the Provider Reimbursement Review Board (PRRB) if they have a common issue of fact, law, or regulation. This provision specifies that if an administrative appeal before the PRRB is brought as a group, then any judicial appeal must be brought as a group. This provision is effective upon enactment.

- Civil Actions -- The provision permits a provider to obtain judicial review of a PRRB decision within 60 days after receipt of notification of that decision rather than within 60 days of the decision itself. This provision is effective upon enactment.

- This provision specifies that for actions brought by groups under the Social Security Amendments of 1983 the effective date is on or after April 20, 1983.

Flexible Sanctions for Noncompliance with Requirements for End-Stage Renal Disease Facilities (Section 2352). Effective on enactment, the Secretary is provided authority to impose intermediate sanctions (rather than decertification) on ESRD facilities or providers that do not cooperate with network plans or goals, provided there is no danger to health and safety of the patients.

Payments to Promote Closure and Conversion of Underutilized Hospital Facilities (Section 2353). The Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35) authorized Medicare and Medicaid payments to cover capital and increased operating costs associated with the conversion or closing of underutilized hospitals. This provision directs the Secretary not to implement that authority and requires the Secretary to study and report on modifications to conform the closure and conversion program to the prospective payment system. The report must be submitted prior to March 31, 1985.

Miscellaneous Technical Corrections Relating to Medicare (Section 2354). This provision makes a number of corrections in the statute which have very minor impact.

Waivers for Social Health Maintenance Organizations (Section 2355). This provision requires that the Secretary approve waivers to demonstrate the concept of social HMO at four sites within 30 days after submission of a waiver request or within 30 days of enactment for those requests pending at enactment. The Secetary must report to Congress on the status of the projects and waivers 45 days after enactment and a final report is due no later than 42 months after enactment.

MEDICAID PROVISIONS

Medicaid Coverage for Pregnant Women and Children (Section 2361)

Current Law: States must provide Medicaid to poor women and children receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. They have the option of extending coverage at their current Federal matching rates to the following additional groups meeting AFDC income and resource requirements: first-time pregnant women who would be eligible for AFDC if the child were born, two-parent families where the principal breadwinner is unemployed, pregnant women in two-parent families, and children under age 18 or 21 in two-parent families (Ribicoff children).

Modification: States are required to provide categorically needy Medicaid coverage at regular Federal matching rates to the following groups meeting AFDC income and resources requirements: (1) first-time pregnant women who would be eligible for AFDC (or would be elgible as AFDC-unemployed parents if the State covered this group) if the child were born, from medical verification of pregnancy, (2) pregnant women in two-parent families where the principal breadwinner is unemployed, from medical verification of pregnancy, and (3) children born on or after October 1, 1983, up to age five, in two-parent families.

Effective Date: October 1, 1984 except that where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Clarification of Medicaid Entitlements for Certain Newborns (Section 2362)

Current Law: Certain States have established Medicaid application procedures that fail to provide for the automatic addition of a newborn child to a Medicaid beneficiary's family unit for coverage purposes.

Modification: States are required to deem as eligible for Medicaid a child born to a woman eligible for and receiving Medicaid at the time of the child's birth. The child must be deemed eligible for one year as long as the woman remains eligible for Medicaid and the child remains a member of her household.

Effective Date: Applies only to children born on or after October 1, 1984.

Recertification of SNF and ICF Patients (Section 2363)

Current Law: Under a State's Medicaid plan, it must show evidence of a satisfactory program of controls over utilization. The program must include evidence that physicians (or a physician assistant or nurse practitioner under the supervision of a physician) recertify the need for continuing skilled nursing facility and intermediate care facility (ICF) services every 60 days. The law requires 100 percent compliance

with the recertification requirements. The Federal penalty imposed on States which fail to have an adequate utilization control program is 33 1/3 percent times the ratio of the number of patients in facilities with one or more records out of compliance to the total number of patients in facilities in the State.

Modifications:

- Recertifications -- The provision provides that physician recertification requirements for both SNF and ICF patients become State Medicaid plan requirements. Recertification of SNF patients is required 30, 60, and 90 days after admission, and thereafter every 60 days. Recertification of ICF patients would be required 60 and no later than 180 days after initial certification, and 12, 18, and 24 months after initial certification, and annually thereafter.

- Grace Period -- The provision permits a 10-day grace period if the State can demonstrate that the physician had good cause for missing the recertification deadline.

- Penalty -- The current penalty will no longer apply to the physician recertification requirements for SNF and ICF patients. However, the current penalty will continue to apply to the requirement that States have an effective program of medical review.

- Secretarial Duty -- The provision reaffirms the Secretary's existing duty to assure that the standards governing the provision of care to Medicaid patients in SNFs and ICFs, and the enforcement of those standards, is adequate to protect the health and safety of the residents and to promote effective and efficient use of public monies.

Effective Date: Beginning July 1, 1984, the current law penalty would not apply to the physician recertification requirements with respect to SNF or ICF patients. The revised certification provisions are effective with calendar quarters beginning on or after enactment, except that no admission occurring before that date will be required to be recertified more frequently than under prior law.

Waiver of Certain Membership Requirements for Certain Health Maintenance Organizations (Section 2364)

Current Law: The proportion of Medicare and Medicaid beneficiaries enrolled in an HMO or other prepaid plan delivering Medicaid services on a risk basis cannot exceed 75 percent of total enrollment. In the case of public HMOs, however, the Secretary may waive the requirement if she determines that special circumstances warrant and the entity is making reasonable efforts to enroll non-Medicare/Medicaid beneficiaries. Medicaid eligibles may disenroll without cause with a one-month notice.

Modification: The Secretary's authority to waiver the enrollment requirements is expanded to include an HMO that is nonprofit, has at least 25,000 enrollees, is and has been a federally qualified HMO for at least four years, provides basic health services through its staff, is located in a medically underserved area, and had previously

received a waiver of the enrollment limitation under section 1115 of the Social Security Act. The Secretary must still determine that special circumstances warrant and that the organization has made and is making reasonable efforts to enroll non-Medicare/Medicaid beneficiaries.

States may require Medicaid beneficiaries who choose to enroll in HMOs meeting certain requirements to remain in the HMO for up to six months, unless the beneficiary has good cause to disenroll before that time. The States must establish effective procedures for reviewing requests for disenrollment on a prompt and fair basis. This restriction could be imposed only where the providers are either federally qualified HMOs or organizations that are receiving and have received (at least two years prior to contracting with Medicaid) grants of at least $100,000 under the Migrant Health Center, Community Health Center, and Appalachian Regional Commission programs. At least 25 percent of the organization's prepaid patients must be other than Medicare or Medicaid beneficiaries.

Effective Date: Upon enactment.

Increase in Medicaid Ceiling Amount for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa (Section 2365)

Current Law: For fiscal years beginning with 1982 the following annual ceilings have been applied to the amount of Federal matching payments which territories participating under Medicaid may receive: Puerto Rico -- $45 million; Virgin Islands -- $1.5 million; Guam -- $1.4 million; Northern Mariana Islands -- $350,000; and (beginning with Fiscal Year 1983) American Samoa -- $750,000.

Modification: The provision raises the ceilings on the amount of Federal matching payments which participating territories may receive to the following levels, effective Fiscal Year 1984: Puerto Rico -- $63.4 million; Virgin Islands -- $2.1 million; Guam -- $2.0 million; Northern Mariana Islands -- $550,000; and American Samoa -- $1.15 million.

Effective Date: Fiscal years beginning with 1984.

Payment for Psychiatric Hospital Services (Section 2366)

Current Law: Reimbursement for hospital inpatients who are awaiting nursing home placement is limited to the State's average daily rate paid for comparable services provided in a skilled nursing facility or intermediate care facility.

Modification: The application of reimbursement limitations with respect to public psychiatric hospitals is delayed until July 1, 1985. The reduction made for the 12-month periods ending June 30, 1986 and June 30, 1987 are one third and two thirds, respectively, of the amounts which would otherwise have been required.

Effective Date: Upon enactment.

Mandatory Assignment of Rights of Payment by Medicaid Recipients (Section 2367)

Current Law: States are permitted to require Medicaid applicants to assign to the State their rights to medical support and third-party payments for medical care.

Modification: States are mandated to require Medicaid applicants to assign to the State their rights to third-party payments as a condition of eligibility.

Effective Date: October 1, 1984, except that where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Requirements for Medical Review and Independent Professional Review Under Medicaid (Section 2368)

Current Law: Medical review requirements for SNFs and independent professional review requirements for ICFs under Medicaid are similar. Both call for teams of physicians, registered nurses, and other appropriate personnel to conduct similar kinds of review.

Modification: The provision makes State plan requirements consistent for medical review and independent professional review for both ICFs and SNFs.

Effective Date: Upon enactment.

Flexibility in Setting Payment Rates for Hospitals Furnishing Long-Term Care Services Under Medicaid (Section 2369)

Current Law: Specific rules are establised for determining payment rates for small rural hospitals furnishing skilled nursing or intermediate care facility services under Medicaid.

Modification: The provision permits States the alternative of paying for long term care services at the designated hospitals either on the basis of the rates provided under current law or on the basis of the same general critera as are applicable to rates for similar services provided by other hospitals and nursing homes. Whatever payment method a State chooses must be applied to all the hospitals in question.

Effective Date: Payments for services provided after the date of enactment.

Authority of the Secretary to Issue and Enforce Subpoenas Under Medicaid (Section 2370)

Current Law: The Secretary is authorized to issue and seek enforcement subpoenas under Medicare to obtain information needed in connection with hearings, investigations, and other matters related to program fraud and abuse.

Modification: The provision authorizes the Secretary to issue and seek enforcement of subpoenas under Medicaid to the same extent allowed under Medicare.

Effective Date: Upon enactment.

Medicaid Clinic Administration (Section 2371)

Current Law: Clinic services are an optional service in the Medicaid program. In some cases, regulations have been interpreted as requiring that clinic administrators be physicians.

Modification: States may cover clinic services furnished by or under the direction of a physician, without regard to whether the clinic itself is administered by a physician.

Effective date: Services provided on or after date of enactment.

Miscellaneous Technical Amendments (Section 2373)

Current Law: Section 137(a)(8) of the TEFRA requires States to use the same methodology for evaluating income and resources of medically needy applicants as is used in the relevant cash assistance program. Strict application of this requirement leads to results which some States and some Medicaid applicants find undesirable.

Modification: Within 12 months of enactment, the Secretary is required to submit a report and recommendations to Congress on the use of rules of the cash assistance programs in cases of Medicaid applicants who do not receive cash benefits. Also, from enactment until 18 months after the Secretary submits the report to Congress, the Secretary is prohibited from imposing any sanctions on States due to their use in medically needy cases of rules that are less restrictive than those of the cash assistance programs.

Effective Date: Upon enactment.

Payment Schedule for Reimbursement of Certain Back Claims Due the States (Section 2637)

Current Law: The Continuing Appropriations for Fiscal Year 1983 act (P.L. 97-276) provided that no payment for pre-1979 Medicaid and certain other program expenditures (including court-ordered retroactive payments) be made until a repayment schedule is established in the Social Security Act.

Modification: A payment schedule is established with respect to court-ordered reimbursements as follows: payment within 30 days of enactment for allowable claims identified in the U.S. District Court decision, State of Connecticut vs. Heckler, and payment for other court-ordered claims for pre-Fiscal Year 1979 expenditures as soon as the Department determines them to be allowable.

Effective Date: Upon enactment.

OTHER CHANGES AFFECTING MEDICAID

AFDC and SSI Eligibility Provisions

Current Law: States are required to provide Medicaid to all recipients of AFDC and most or all recipients of Supplemental Security Income payments. Therefore, changes in the number of eligibles in these programs directly affect Medicaid caseloads and program costs.

Modification: A number of changes were made to both programs. Those with the biggest impact on Medicaid by expanding the number of eligibles include: (1) a work transition provision requiring States to extend Medicaid for nine additional months (six more at State option) to working families who lose AFDC when all their earnings are counted; and (2) a requirement to include the parents and all minor siblings living with the dependent who is applying for or receiving AFDC.

Effective Date: October 1, 1984.

Income Eligibility Verification Procedures

Current Law: Information from the IRS and State unemployment compensation programs is not available on the same terms to all State and Federal agencies administering means-tested welfare and health programs.

Modification: States must have in effect an income and eligibility verification system for use in administering the AFDC, Medicaid, unemployment compensation, and food stamp programs. The IRS will disclose information on unearned income on State request, which is mandatory. State programs must use standardized information formats, contain safeguards on confidentiality, and include measures to protect applicants or recipients from the consequences of erroneous information.

Effective Date: Except as otherwise specified, April 1, 1985.

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